Department of Veterans Affairs **VHA DIRECTIVE 98-023**
Veterans Health Administration
Washington, DC 20420 **April 17, 1998**

GUIDELINES FOR IMPLEMENTATION OF PRIMARY CARE

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes guidelines and provides direction for the implementation of primary care at all Department of Veterans Affairs (VA) medical facilities and at off-site locations.

2. BACKGROUND

a. The varied and complex array of health-related interventions and resources needed to care for veterans necessitates a high degree of coordination and integration of services within and among service providers. VHA needs to assess its resources to determine services that must be enhanced, reduced, or modified in order to provide the highest quality of healthcare to veterans.

b. Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. This effort is to facilitate a shift from the provision of episodic care to delivery of a coordinated, continuum of care emphasizing primary care within referral networks. Primary care will provide the best mechanism to ensure the provision of quality healthcare.

c. Primary care is healthcare which emphasizes the point at which the patient usually first seeks assistance from the healthcare system. Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. It consists of intake, initial assessment, health promotion, disease prevention, emergency services (commensurate with the facility capability), management of acute and chronic biopsychosocial conditions, referrals for specialty, rehabilitation, and other levels of care, follow-up, overall care management, and patient and caregiver education.

d. The need to implement primary care throughout VHA has been recognized and encouraged in the "Vision for Change," the "Prescription for Change," and the "Journey of Change." A recent Primary Care Survey conducted by the National Center for Cost Containment, Milwaukee WI, and the Office of Primary and Ambulatory Care, showed that VHA had made progress in implementing primary care. There is still work to be done to reach 100 percent implementation. The 1998 Network Directors' Performance Agreements call for 80 percent of ambulatory care patients to be enrolled in a primary care program by September 30, 1998. VHA healthcare facilities can request a Primary Care Consultation and Education Team (PCECT) to assist them in implementing or improving their primary care programs by contacting the Office of the Chief Consultant Primary and Ambulatory Care. The Employee Education System, Northport Center, NY, has provided to VA medical centers eighteen CD ROMs entitled "Primary Care Core Curriculum." They have Primary Care Implementation Modules for use at local facilities. The modules include: Managing Change, Strategic Planning (self-directed), Team Development, Patient and Family Education, Information Management (self-directed) Performance Measures (self-directed), Ethical and Legal Issues, and Medical Faculty Development. ***NOTE:*** *Additional information can be obtained by contacting the Northport Center.*

THIS VHA DIRECTIVE EXPIRES APRIL 17, 2003

3. POLICY: It is VHA policy that primary care will be provided to to all eligible veterans requiring coordinated care; and that the basic attributes of primary care are ensured for each eligible veteran. Focusing on quality management and improvements in attributes such as accessibility, timeliness, and continuity of care, all primary care programs will ensure that the following basic attributes of primary care are present:

a. **Care is Accessible**. Care that is accessible allows patients to enter a care system easily and expeditiously.

b. **Care is Timely**. Care is provided in a timely fashion when needed, whether for minor illness or for emergencies. VHA's national timeliness standards on urgent, symptomatic, routine, and follow-up appointment scheduling are included in the VA's "Putting the Veterans First" Customer Service Plan, dated August 1994, Section 2.22. These standards must be complied with in developing primary care programs.

c. **Care is Coordinated**. Primary care extends beyond the outpatient environment and addresses the needs of patients in the hospital, nursing home, and home care environment; includes both institutional and non-institutional care. The coordination of care shall assure that redundant services are avoided, that referrals are appropriate and timely, and that needed information is readily and immediately available to all providers.

d. **Care is Continual**. Continuity of care may be assured through the effective coordination of care by a primary care provider. To provide continuity, the primary care provider must be backed by a team who knows the patient well. An effective and appropriate communication system will facilitate continuity of care and ensure notification to provider of patient encounters other than scheduled visits.

e. **Care is Comprehensive**. Comprehensive care addresses the need for all healthcare components to be available and accessible to all patients. Availability of the breadth of these services will be addressed through an itemization of the various program components and periodic utilization review. Provision must be made to meet the special needs of female veterans, such as gynecological services or the establishment of women's clinics allowing female patients to be seen by the same provider or team whenever possible.

f. **Care is Compassionate, Concerned, and Focused on the Patient's Healthcare Needs**. Management will ensure that patients can identify their primary care providers or their primary care teams.

4. ACTION: Primary care will be implemented at all VHA facilities. ***NOTE:*** *Implementation will require local redirection of resources within the various levels of care. It is recognized that a shortage of primary care providers exists and the retraining of interested clinical staff may be necessary to ensure the provision of primary care.*

a. **Providers.** Delivery of healthcare often involves many different providers, and it is important that one provider or team have overall responsibility. Patients must know whom to contact when they need help or have a problem.

(1) **Primary Care Provider**

(a) Every patient enrolled in primary care must have a primary care provider who is a physician or an advanced practice nurse or a physician assistant. Primary care will be delivered in an interdisciplinary setting. The provider will be supported by a team of clinical and administrative personnel.

(b) Besides the generalist, a specialist in certain instances may provide primary care. For example, a psychiatrist may be the primary care provider for some patients with schizophrenia or chronic mental illness; and a geriatrician may provide primary care to elderly patients with complex or multiple healthcare problems. The subspecialist serving as a primary care provider may be responsible for the large majority of patient's healthcare needs. Also, certain subspecialists assume primary (total) care of a cohort of patients (e.g., oncologists, dialyzing nephrologists, etc.).

(2) **Primary Care Team**

(a) The core primary care team should typically include a responsible clinician (physician, nurse practitioner, or physician assistant), a care manager, a staff nurse, MAS staff and a health technician. The team may also include specialist physicians, psychologists, psychiatrists, optometrists, podiatrists, dentists, pharmacists, dietitians, rehabilitation therapists, and any other discipline involved in the delivery of patient care. The composition of the team will vary depending on the needs of patients allowing local flexibility and innovation.

(b) The team will provide medical, nursing, and psychosocial services, ongoing and preventive healthcare services, health education to patients and caregivers, access to VA services and programs, community resources, and continuity in the absence of the primary care provider. The primary care provider and the support team constitute the functional unit through which the veteran will interact with the healthcare system, but the concept that patients and care managers are team-specific is constant.

b. **Responsibilitites**

(1) **Primary Care Providers**

(a) Primary care providers are responsible for having an understanding of common presentations of illnesses; training in disease prevention and health education; strong skills in history taking, physical examination, acquisition, analysis, and synthesis of data; and highly developed communication skills.

(b) The primary care provider or team assumes responsibility for planning, coordinating and ensuring continuity of care for the patient including maintenance of health and treatment of illness.

(c) The primary care provider is responsible for delivering cost-effective care and referring patients to other specialized services when appropriate**.** ***NOTE:*** *Referrals may include VA resources, consultants and community services.*

(d) The primary care provider works effectively with other healthcare providers, coordinates services of an interdisciplinary healthcare team and participates in utilization and quality of care review activities.

(2) **The Chief Consultant Primary and Ambulatory Care**. The Chief Consultant Primary and Ambulatory Care has evaluation, oversight responsibility and develops policy for the primary care program at the national level.

(3) **Network Directors**

(a) Network Directors will ensure that primary care is provided at all VHA healthcare facilities in their service areas and will ensure coordination of all primary care activities within the referral networks and across networks.

(b) Networks must provide care directly, by contract or sharing agreement, or by referral to other networks**.** ***NOTE:*** *Situations may arise when due to resource constraints, VA must delay the provision of non-emergent care (e.g., delays in clinic appointments), or provide care in a limited number of locations that may not be convenient to an enrolled veteran. In those instances, a veteran with other healthcare coverage may choose to seek care through those sources instead.*

(4) **Network and Facility Directors**

(a) Network and facility Directors are responsible for the implementation and effectiveness of primary care. For example, the veteran may have private health insurance or Medicare or might be eligible for care from the Department of Defense (DOD) (TRICARE). Under no circumstance may VA refuse care to an enrolled veteran because the veteran could receive care through another source. If an enrolled veteran chooses to use an alternative eligibility to obtain a particular service, VA providers should be aware of the care a veteran receives from another source. This is to ensure that VA does not duplicate the care provided from a non-VA source, and to ensure the quality and appropriateness of the care VA does provide to the enrolled veteran.

(b) VHA Network and facility directors will ensure that eligible veterans seeking coordinated care have a primary care provider identified who is responsible for the management of the veteran's care through the continuum of healthcare services.

(c) As defined in each Network, Service Line Directors and/or Directors of VHA healthcare facilities are responsible for the development of a primary care program structure and the implementation of primary care to meet the needs of veterans in their service areas. Each service line director and/or facility Director will be responsible for the development of a primary care program based on the case mix of the veteran population to be served, geographical considerations, facility mission, staffing considerations and available resources. Primary care may be provided by VA staff or a combination of VA staff and contractors. Quality outcomes and measures should be a part of any contract for primary care.

5. REFERENCES

a. "Vision for Change," March 1995.

b. "Prescription for Change," June 1996.

c. "Journey of Change," March 1997.

d "Annual Ambulatory Care Customer Feedback Survey," National Customer Feedback Center, West Roxbury, MA, 1997.

e. Donaldson, Molla; Yordy, Karl; Vanselow, Neal; editors; Defining Primary Care; An Interim Report, National Academy Press, Washington, DC, 1994.

f. Semi-annual Primary Care Surveys, conducted by the National Cost Containment Center, Milwaukee, WI, 1997.

g. "Guide to Clinical Preventive Services," Second Edition, Report of the U.S. Preventive Services Task Force, Williams and Wilkens, 1996.

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant Primary and Ambulatory Care (112) is responsible for the contents of this VHA Directive.

7. RESCISSIONS: This VHA Directive will expire April 17, 2003.

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Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 4/17/98
FLD: RD, MA, DO, OC, OCRO and 200 - FAX 4/17/98
EX: Boxes 104, 88, 63, 60, 54, 52, 47 and 44 - FAX 4/17/98

ATTACHMENT A

IMPLEMENTING A PRIMARY CARE INITIATIVE

1. The major elements required to implement a primary care initiative within the Veterans Health Administration (VHA) are:

a. Definition of population to be served,

b. Description of services to be provided, and

c. Allocation of staff and resources.

2. The following actions are suggested for implementing primary care:

a. Define the patient population by reviewing the existing specialty clinics and identifying patients who can be more appropriately treated in primary care clinics. Develop a process or methodology to accurately project the anticipated number of patients to be treated in primary care clinics (refer to Att. B, Suggested Needs Assessment Methodology for the Primary Care Program).

b. Identify the geographic service area to be served.

c. Develop a primary care program structure and initiate its use for the current patient population. There are Department of Veterans Affairs (VA) facilities which have implemented primary care programs effectively and their positive experiences may be of assistance. A list of these facilities can be obtained through the Office of the Chief Consultant Primary and Ambulatory Care, VHA Headquarters.

d. Establish primary care networks and referral sites. Establish a network committee to serve as a forum for improving each facility's provision of care. The primary care network should make effective use of community resources. Establish community health and social service networks as a part of the primary care continuum of care to sustain the veteran in the community setting, ordinarily the patient's own home. Veterans have many entitlements separate from VA eligibility which can and must be pursued consistent with the veterans' healthcare plans.

e. Identify basic primary care services (such as screening, health promotion, prevention, education etc.) as well as support services required (such as X-ray, Laboratory, Automatic Data Processing, etc.) to support efficient primary care.

f. Develop medical center infrastructure plans to address needs related to providing primary care. Emphasize short-or near-term actions, (e.g., minor construction) to upgrade primary care service delivery. These include patient parking, patient privacy and waiting areas.

g. Define clinic hours of operation based on efficiency and convenience to veterans.

h. Identify staffing requirements to ensure that the ratio of veterans to providers is large enough to promote efficiency but not so large as to become unmanageable.

i. Consult and coordinate with affiliates to provide an environment for training primary care providers. Work closely with affiliates to gain support for providing primary healthcare where there is an excess of specialists and a shortage of primary care providers. The successful implementation of this cultural change in VHA will require the full cooperation of affiliated health professions schools.

j. Educate and train staff about the new primary care culture. Retrain interested specialists to provide primary care and recognize those who successfully make this transition. Provide training for interdisciplinary teams including attending physicians, residents in medicine, dentistry, podiatry, optometry, psychology, pharmacy, associated health profession trainees in social work, nursing, and other disciplines. Medical center management should become active participants in educating the employees and healthcare community.

k. Provide advance notification to patients regarding the shift to a patient-focused primary care culture and explain the benefits of the shift for the patient and family. Work with local Veterans Service Organizations to gain their support.

l. Develop local standards (must be equivalent to or better than the national standards set by VHA Headquarters) to evaluate customer satisfaction, clinical quality, and cost-effectiveness. The standards should be the same for both VA and contracted services. Outcome-oriented quality improvement programs will be an integral part of the utilization management and cost-containment processes. Identify best practices in the community and compare VA's outcomes to those of Health Maintence Organizations (HMOs), Preferred Provider Organizations (PPOs), health departments and other systems which provide services to similar populations. Utilize focus groups of veterans as part of the quality improvement program to assess the care components of the system. Make provision for computer support to facilitate data analysis (refer to Att. C for Suggested Performance Measures).

m. Determine research activities locally based on local needs and areas of expertise. Research programs will be considered an integral component of primary care to assure the most up-to-date and highest quality of medical care.

ATTACHMENT B

PRIMARY CARE PROGRAM
SUGGESTED NEEDS ASSESSMENT METHODOLOGY

The following methodology is provided to assist planners in projecting workload for primary care program:

1. PLANNING ASSUMPTIONS

a. Primary care will be available to veterans within a reasonable distance from their residence. ***NOTE:*** *Reasonable distance will be determined locally.*

b. Although all patients may be candidates for primary care, it is assumed that patients with multiple outpatient visits and patients using pharmacy services regularly (more than for a single non-refillable prescription) will require coordinated care and should be enrolled in primary care.

2. APPROACH TO NEEDS ASSESSMENT METHODOLOGY

This methodology will provide an approach to projecting future workload based on past utilization rates of Department of Veterans Affairs (VA) facilities. The methodology consists of the following parts:

a. Projecting primary care workload generated by current patients residing within a determined distance of a VA medical center.

b. Projecting workload generated by current patients residing beyond the established distance of the VA facility.

c. Determining network workload.

d. Determining need for new primary care access points.

e. Impact on Specialty Clinics

3. METHODOLOGY

a. **Determine Primary Care Workload for a VA Facility**. Determine primary care workload for a VA facility within the established distance:

(1) Determine the unique patients that required three or more outpatient visits per year during the 3 most recent years (there may be exceptions to this requirement based on the movement to managaged care).

(2) Perform a patient home zip code and county analysis of those who required three or more outpatient visits per year for the 3 most recent consecutive years, and determine the number of

unique patients who reside within an established distance of the VA facility, by eight age groups.

Example: ***NOTE:*** *Use most recent 3 years of data*

Number Of Unique Patients Within an Established Distance of a VA Facility

Age Group	Year 1	Year 2	Year 3	Mean (Yr 1-3)	Mean SS#/ 1000 Vet Pop(Yr3)
>25					
25-34					
35-44					
45-54					
55-64					
65-74					
75-84					
85+					

(3) Projection

Example. VA Medical Center and Age Specific Projection Methodology.

VA Medical Center Mean Unique		Projected Year		Projected Year
patients per 1000 veterans (by age group within established distance)	X	veteran population (by age group within established distance of VA medical center)	=	primary care (unique patients by age group within established distance)

(4) Add all eight age groups projected workload to get total projected year primary care unique patients.

(5) Total Visits. It is assumed that for primary care each patient would require an average number of about six to seven visits per year. This number may need to be adjusted based on local case-mix.

Example

Total number of unique patients		Average number of visits per pt per year		Total number of visits projected for primary care
	X		=	

b. **Determine Primary Care Workload Generated by Patients**. Determine primary care workload generated by patients residing in areas beyond the established distance from the VA medical center within the network: Perform a home zip code and county analysis for unique patients living beyond established distance from the VA facility. Project the number of visits using the same methodology described above.

c. **Network Workload (primary care visits).** Determine total primary care visits projected for each VA facility within established distance and beyond (see subpar. 3a and 3b). Add the total visits for the network. To allow for flexibility, planning will be network based rather than facility specific

d. **Determine Need for New Primary Access Points**. Once the population of current patients to be enrolled in primary care is determined, the demographics of these patients and potential users should be examined to determine possible need for new access points. Establishing a new VA primary care access point for workload below 2000 visits per year may not be cost-effective. Arrangements for primary care can include but not be limited to sharing agreement, contract, fee-basis care, purchasing care, etc. Determine the best arrangement for providing primary care to veterans.

e. **Impact on Specialty Clinics**. Examples of workload that can be appropriately managed in primary care are as follows:

Hypertension	Ischemic Heart Disease
Diabetes Mellitus	Rheumatoid Arthritis
Degenerative Arthritis	Constipation
Congestive Heart Failure	COPD (Chronic Obstructive Pulmonary Disease)
Preventive Medicine Procedures	Pap Smear
Anxiety - Depression	Mammograms
Peripheral Vascular Disease	Testing for Occult Blood
Peptic Ulcer Disease	Vaccines
Urinary Tract Infection	Cholesterol Screening
Chronic Pain Management	Pelvic Exam
Asthma	Breast Exam
Substance Abuse Screening	Dental Evaluation

Review specialty clinics workload for their appropriateness for primary care program. This will assist in estimating impact on specialty clinics.

ATTACHMENT C

SUGGESTED PRIMARY CARE PERFORMANCE MEASURES

The following measures are suggested for internal performance monitoring purposes. These measures are consistent with attributes of primary care. Quality and performance are not independent. Primary care programs should be monitored for quality using established standards and quality indicators.

1. Utilization

a. Bed days of care per 1,000 patients;

b. Admission rate per 100 patients assigned to primary care provider;

c. Average length of stay per 100 primary care patients;

d. Distribution of outpatient visits by clinic enrollment and by number of visits per patient;

e. Beginning in Fiscal Year (FY) 1999, number of patients per primary care provider;

f. Beginning in FY 1999, number of referrals and consults within the Department of Veterans Affairs (VA) per patient by primary care provider; and

g. Beginning in FY 1999, number of ancillary tests per provider per 100 patients.

2. Access and/or Availability

a. Percent of eligible veterans in a locally determined geographic area;

b. Travel time to primary care site;

c. Ratio of various types of clinicians to patient population;

d. Lead time for routine office visits (percent of patients that can be scheduled for routine office visits within 7 days);

e. Percent of unscheduled walk-in and/or emergency room visits;

f. Telephone response time for patient services; and

g. Average time between time scheduled and time seen.

3. Continuity

a. Primary care provider turnover rate;

b. Percentage of primary care patients enrolled in specialized clinic with large case management programs, such as, Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), oncology, mental health , substance abuse treatment, etc.;

c. Disenrollment rates per year and the results of disenrollee surveys; and

d. Percent of patients who have two or more visits with the same provider.

4. Health Outcome

Review deaths, complications, morbidity rates, disease management, i.e. vision loss, amputation rates and glycemic control in diabetics.